The MIPESA Newsletter

Malaria In Pregnancy East and Southern Africa: Coalition for Prevention and Control

Issue 1 April 2004

MIPESA MEMBERS

- KENYA
- MALAWI
- TANZANIA
- UGANDA
- ZAMBIA

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Editorial

The MIPESA Coalition

It is pleasing to see that MIPESA (Malaria in Pregnancy East and Southern Africa: Coalition for Prevention and Control) is forging ahead with its mission of sharing best practices, successes, resources, and expertise in the important task of preventing and controlling malaria during pregnancy. The launch of this newsletter will help ensure more effective communication not only within the ranks of coalition members and our partner stakeholders but also, I hope, with the wider "malaria community."

About the coalition

MIPESA was established in Entebbe in June 2002 by Kenya, Malawi, Tanzania, Uganda, and Zambia and functions with support from various partners, including CDC, JHPIEGO, the Malaria Consortium, UNICEF, USAID, and WHO. The Regional Centre for Quality of Health Care in Kampala houses MIPESA's secretariat.

We in MIPESA recognise that the war on malaria in pregnancy cannot be won without the strong collaboration of malaria control programmes (technical advisors) and reproductive health programmes (implementers) within and among countries and also regionally. Therefore, malaria-in-pregnancy task forces within countries comprise members from both programmes, and MIPESA's chairperson and vice-chairperson represent both programmes.

All members have reaffirmed their commitment to providing prompt, effective case management for pregnant women and have adopted intermittent preventive treatment with sulphadoxine-pyrimethamine (IPT-SP) and insecticide-treated nets (ITNs) for preventing malaria during pregnancy. Information shared at our general meetings (Entebbe, June 2002; Lusaka, February, and Dar-es-Salaam, September, 2003) shows that since MIPESA's inception, differences among members in stages of implementing these interventions are narrowing.

Our challenges

To have an impact on morbidity and mortality from malaria among pregnant women and their babies, we need to grapple with some critical issues, including:

- Number of IPT-SP doses needed in countries with high HIV prevalence
- Scale-up of ITN availability, distribution, and retreatment through a variety of methods
- Promotion of operational research and sharing experiences/best practices
- Coalition capacity for advocacy
- Skills/knowledge of health personnel in antenatal clinics; inadequate staffing levels
- Provision of safe water at health facilities for IPT provided as directly observed therapy (DOT)
- Alternative drugs for IPT as resistance increases

As part of our efforts to obtain more resources to address some of these issues, MIPESA's Steering Committee submitted a Global Fund proposal last year. We have just responded to concerns by the Fund's technical review panel and readied the proposal for resubmission.

The support of our public– and private-sector partners will be important, as will our commitment to ensuring high national coverage with effective interventions—interventions that can make a difference to the health of pregnant women and their newborns.

Dr. Peter Kazembe, chairman, Malawi's National Malaria Technical Committee, serves as MIPESA's chairman. pnkazembe@malawi.net

The first in the region to adopt IPT-SP, Malawi tracked implementation to be sure pregnant women were receiving the recommended number of doses. When it was found they weren't ...

A pregnant woman in Malawi receives IPT as directly observed therapy (DOT).

"We were told that malaria can silently kill a baby in the womb. That is why I sleep under a mosquito net and take that medicine they give us at the clinic. I do not want to take chances!"

Pregnant woman, Uganda

Sharing National Successes

Malawi's Story

More than a decade ago, in 1993, Malawi adopted and implemented a policy of intermittent preventive treatment (IPT, or as Malawi's Ministry of Health prefers, PIT) (2 doses with sulphadoxine-pyrimethamine [SP]) for pregnant women. However, studies in the early 2000s showed only a small percentage of pregnant women were receiving both recommended doses. In 2000, a Demographic and Health Survey showed that only 29% of pregnant women in Malawi received the recommended number of IPT doses, although 90% visited antenatal clinics at least twice during pregnancy.

Malawi then focused its attention on one district in the south, Blantyre, to determine why this was happening.

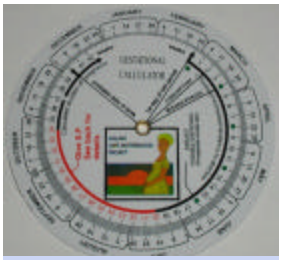
A study conducted in 12 health centres found the chief problem was confusion among health staff about timing of doses, including overstrict adherence to the timetable laid out in the policy, which stated the 2nd dose be given between 28-34 weeks. Staff were also not clear about the required interval between the 1st and 2nd doses. Identification of trimesters was also problematic. Directly observed therapy (DOT) (observation of SP being taken in health facilities) was found to be signficantly related to receipt of a second dose, but was practiced in only half of the health centres.

An intervention was designed to address these problems and then carried out.

The intervention . . .

The national policy was revised: All pregnant women should receive at least 2 doses of IPT-SP after quickening, at least one month apart. The investigators gave tailored feedback to each facility, communicating the revised policy, highlighting the facility's strengths and weaknesses, providing plans for reorganizing patient flow to promote DOT, and providing low-cost job aids (posters, gestational dosing wheels) and flyers.

A follow-up visit showed the intervention worked. **IPT coverage increased from 45% to 79%, exceeding the Abuja target of 60%.** In addition, 82% of pregnant women could identify the benefits of IPT-SP compared with 49% before the intervention.

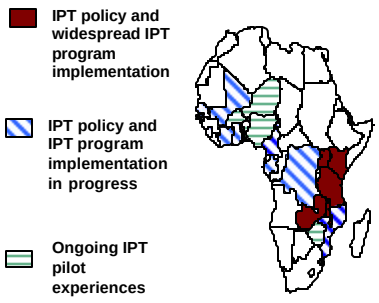


A gestational wheel helps health workers determine proper timing of IPT dosing.

Malawi is now "scaling up" this simple, low-cost intervention, which can be adapted and used in other countries throughout the region.

Sharing Regional Successes

IPT Implementation Status



São Tomé and Principe have adopted IPT; implementation is in progress.

April 2004

MIPESA countries were among the first in the region to adopt and implement IPT as policy.

New Network Formed

In October 2003, a little more than a year after MIPESA's launch, West African countries joined to form a network to address the prevention and control of malaria in pregnancy, based on the MIPESA model. Founding members of RAOPAG (Réseau d'Afrique de l'Ouest contre le Paludisme pendant la grossesse), Benin, Burkina Faso, Côte d'Ivoire, Mali, Senegal, and Togo, have been joined by Gambia, Guinea, Madagascar, Mauritania, Niger, and Sierra Leone. Ghana, Liberia, and Nigeria are taking steps toward joining RAOPAG.

Technical Update from WHO/AFRO and WHO/Headquarters

Recommended Interventions for Malaria Prevention and Control during Pregnancy (in areas of stable transmission)

Note: The following is from ***Malaria Prevention and Control during Pregnancy in the African Region*** (in press), a collaborative effort of the Malaria Control Programme and the Safe Motherhood Programme of the Regional Office for Africa of the World Health Organisation (WHO/AFRO) and the Roll Back Malaria and Making Pregnancy Safer teams of the Headquarters of the World Health Organisation.

The policy for malaria prevention and control during pregnancy in areas of stable transmission should emphasise a preventive package of intermittent preventive treatment (IPT) and insecticide-treated bed nets (ITNs) and ensure effective case management of malaria illness and anaemia.

- **Intermittent Preventive Treatment**

All pregnant women in areas of stable malaria transmission should receive at least 2 doses of IPT after quickening. The World Health Organisation recommends a schedule of 4 antenatal clinic visits, with 3 visits after quickening. The delivery of IPT with each scheduled visit after quickening will assure that a high proportion of women receive at least 2 doses. IPT-SP doses should not be given more frequently than monthly.

The most effective drug for IPT is sulphadoxine-pyrimethamine (SP) because of its safety for use during pregnancy, effectiveness in reproductive-age women, and feasibility for use in programmes, as it can be delivered as a single-dose treatment under observation by the health worker.*

- **Insecticide-Treated Nets**

ITNs should be provided to pregnant women as early in pregnancy as possible. Their use should be encouraged for women throughout pregnancy and during the postpartum period. ITNs can be provided either through the antenatal clinic or other sources in the private and public sectors.

- **Case Management of Malaria Illness and Anaemia**

Effective case management of malaria illness for all pregnant women in malarious areas must be assured. Iron supplementation for anaemia should be given to pregnant women as part of routine antenatal care. Pregnant women should also be screened for anaemia, and those with moderate to severe anaemia should be managed according to national reproductive health guidelines.

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* Current scientific evidence suggests the following: 1) At least 2 IPT doses are required to achieve optimal benefit in most women; 2) One study of IPT in HIV-infected pregnant women has demonstrated that monthly dosing of IPT (with most women getting 3-4 doses) was necessary to achieve optimal benefit; 3) In settings with HIV prevalence in pregnant women greater than 10%, it is more cost effective to treat all women with a 3-dose regimen than to screen for HIV and provide this regimen only to HIV-infected women; 4) There is no evidence that a third dose of IPT causes any additional risk, that more than 3 IPT doses during pregnancy offers additional benefit, or that receiving 3 or more doses of IPT with SP will result in an increased risk of adverse drug reactions. Research to assess the safety, efficacy, and programme feasibility of other antimalarial drugs for use in IPT is ongoing.

RESOURCES

CD-ROM

MNH's Malaria during Pregnancy Resource Package: Tools to Facilitate Policy Change and Implementation. Available on line in English and French at www.mnh.jhpiego.org and by request from RCQHC.

Web Sites

JHPIEGO www.jhpiego/org
Making Pregnancy Safer www.who.int/reproductive-health/mps/
Malaria Consortium www.malariaconsortium.org
PREMA-EU www.prema-eu.org/
RBM http://mosquito.who.int
WHO/AFRO www.afro.who.int

Recent Articles

Holtz TH, Kachur PS, Roberts JM et al. Use of antenatal care services and intermittent preventive treatment for malaria among pregnant women in Blantyre District, Malawi. Trop Med Int Health. 2004 Jan; 9(1): 77-82.

Newman RD, Parise ME, Slutsker L et al. Safety, efficacy and determinants of effectiveness of antimalarial drugs during pregnancy: implications for prevention programmes in *Plasmodium falciparum*-endemic sub-Saharan Africa. Trop Med Int Health. 2003 Jun; 8(6): 488-506.

Parise ME, Lewis LS, Ayisi JG et al. A rapid assessment approach for public health decision-making related to the prevention of malaria during pregnancy. Bull World Health Organ. 2003; 81(5): 316-23.

Shulman CE, Dorman EK. Importance and prevention of malaria in pregnancy. Trans R Soc Trop Med Hyg. 2003 Jan-Feb; 97(1): 30-5.

ter Kuile FO, Terlouw DJ, Phillips-Howard PA et al. Reduction of malaria during pregnancy by permethrin-treated bed nets in an area of intense perennial malaria transmission in western Kenya. Am J Trop Med Hyg. 2003 Apr; 68(4 Suppl): 50-60.

van Eijk AM, Ayisi JG, ter Kuile FO et al. Effectiveness of intermittent preventive treatment with sulphadoxine-pyrimethamine for control of malaria in pregnancy in western Kenya: a hospital-based study. Trop Med Int Health. 2004 Mar; 9(3): 351-60.

From WHO, from the Field ... LLNs

WHO Reviews Another LLN

The 7th WHO Pesticide Evaluation Scheme (WHOPES) Working Group met at WHO headquarters in Geneva, 2-4 December, 2003 and reviewed results of laboratory and field studies of PermaNet® 2.0, a long-lasting insecticidal net (LLN).

After considering the safety, efficacy, and wash-resistance of PermaNet 2.0, the group gave an *interim* recommendation for its use in the prevention and control of malaria. It encouraged WHO to support and facilitate large-scale field studies of PermaNet 2.0 to confirm long-lasting efficacy for malaria and other vector-borne disease prevention and control in different settings.

Currently, the only LLNs recommended by WHO for malaria prevention and control are PermaNet 2.0 and the Olyset Mosquito Net.

Look for an update on ITNs in a future issue of The MIPESA Newsletter.

Tanzanian Firm First to Produce LLNs

In September 2003, A to Z Textile Mills, Ltd., Tanzania, became the first in Africa to produce long-lasting insecticidal nets (LLNs), with help from the Acumen Fund and the inventor of the technology, Sumitomo Chemical Company, which provided the necessary machinery and chemicals to produce Olyset Mosquito Nets. The availability of nets that do not need retreating every 6 months or so promise to make net use an even more effective intervention. The firm anticipates producing 400,000 nets per year, which will be sold to the local market, with export to follow later. Tanzania aims to increase accessibility and affordability by providing pregnant women vouchers to obtain either an ITN or LLN at a greatly reduced price in selected commercial outlets beginning in April 2004.

UPCOMING EVENTS

- **March 29—April 2** Malaria Prevention and Control during Pregnancy (training workshop). Conducted by JHPIEGO and RCQHC. Entebbe, Uganda
- **April 25** Africa Malaria Day
- **April 29—30** RBM Partnership Malaria in Pregnancy Working Group Meeting. Accra, Ghana
- **May 3—14** Global Fund Technical Review Panel Meeting. Geneva, Switzerland
- **August 9—20** Quality of Health Care (course). Conducted by RCQHC, with support from USAID/REDSO/ESA. Jinja, Uganda

QUESTIONS OR COMMENTS ABOUT MIPESA OR THIS NEWSLETTER?

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